larger number of patients suffering from chronic amebiasis belong to the last subdivision—the atypical.

HERBERT GUNN, M. D. (350 Post Street, San Francisco)—Just as Dr. Davidson says, since the war the attention of the medical profession has been focused on the subject of amebiasis, and the fact that now many more physicians are on the lookout for it accounts, I believe, largely for the apparent increase noted in its incidence.

That still many medical men require to have the subject drawn to their attention is evidenced by the frequency with which the disease is overlooked—either not thought of at all or sought for by unsuitable methods and overlooked.

At the present time I have under observation two patients who, not being relieved of symptoms by appendectomies, were investigated for amebic infection and found positive.

Routine examination of the stools in such cases, as advocated by Davidson, would practically make impossible such gross errors.

EVOLUTION OF THE SURGEON FROM THE GENERAL PRACTITIONER †

By A. S. MUSANTE *

(From the Division of Surgery, St. Joseph's Hospital, San Francisco)

IT IS my purpose to briefly discuss the manner by which a doctor ambitious to do surgery can, with profit, first spend a preliminary period in general practice, rather than to plunge, immediately after graduation, into specialized operative work or post-graduate surgical study. If it can be shown that five, ten, or more years of general practice in medicine and surgery and, after that, specialized post-graduate surgical study is the proper preparation for prospective operators, it will be very satisfying. If it should be evident that a surgeon without preliminary general practice, but with only a year's post-graduate study or less is apt to fall short in diagnosing and treating many complaints apparently within his field, because the patient's abnormality in its entirety is not thoroughly comprehended, it will establish the conviction aimed at.

HOSPITAL SHOULD PREVENT IMPROPER OPERATIONS

The question of whether a surgeon is doing proper work or, instead, is performing useless operations or raising the mortality rates is of much importance nowadays to those who are in charge of hospitals, as the American College of Surgeons and American Medical Association make it the duty of the hospitals, among other things, to review the work of the doctors so as to prevent avoidable operations and deaths. Instances of certain doctors being denied the privilege of practicing in hospitals, because of their incompetency or unscrupulousness, have been brought to our attention and courts have upheld those who sought to prevent unnecessary or poorly performed operations. In fact, the time has passed, with the progress of our institutions, when in worthy hospitals patients are at the mercy of incompetent or dishonest doctors, those in charge of these hospitals having risen to the high and noble plane of feeling responsible for the proper care of the sick and injured coming under their charge.

SURGICAL COMPLAINT OFTEN DECEIVING

May I recite an instance which impressed me with the advantage that would redound to a surgeon and his patients if five or ten years of general practice were engaged in by those who wish to be surgical operators? A woman, 32 years of age, was brought to me about ten years ago with a history of having been operated upon for bleeding piles by a prominent surgeon one year before. The piles had returned and the same surgeon desired to operate again, but the patient was not willing. It was not difficult to discover that her present and previous piles were due to a well-developed case of cirrhosis of the liver. Regulation of this woman's diet corrected her hemorrhoids, although the liver condition very rapidly caused her death. If the surgeon she consulted at the time she first complained of piles had made a correct diagnosis he would not have operated upon her for piles, but may have done a Talma operation for the cirrhosis which might have helped her very much. When I saw her, the liver condition was too advanced and rapid for any such procedure, and she died after six months.

GENERAL PRACTICE A GOOD SURGICAL PRELIMINARY

A surgeon without a wide foundation of general practice cannot build his surgical career as solidly as if he had a long, broad experience in general medicine. It is true that every surgeon has had a course in college covering all the maladies "that flesh is heir to," but no deep-thinking person would claim that this is enough to diagnose and treat correctly all that had been studied, unless it is followed by practical experience in handling repeatedly the different diseases. As a matter of fact, every doctor—whether specialist or general physician—should have a sound knowledge of the entire field of medicine and surgery, so that if called upon, especially in an emergency, he will by his conduct reflect credit upon our profession which he upon such occasion represents. He would not be guilty of the conduct of a certain specialist who, while on his vacation, was asked to see a teacher who had fainted. Finding her prostrate and unconscious, this doctor declared he was a specialist and knew nothing about what ailed the patient and left her. The next physician called found that the bystanders had done what should have been ordered by the specialist. The most difficult problem of the second doctor was to deal with the adverse criticism that was being heaped upon the previous doctor.

One who precedes his surgical work with general practice as a rule has a good deal of experience with surgical consultants and operators, whom he assists many times, and this contact will not only be valuable from a teaching standpoint, but it will enable him to discover if he is fit for the trying situations

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† Read before the Catholic Hospital Association, September 23, 1925.

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of the surgery. We all know of persons who, instead of stepping from general practice to a specialty, have reversed matters and given up specialized work to take up the labors of the general practitioner.

The new M. D. who, with or without post-graduate surgical study, attempts surgical specialization, is apt to find it more difficult to develop a successful practice in his specialty than the one who has found in his years of general practice that he is being consulted for surgical conditions more and more, becoming quite capable to decide which cases need operation—the most important qualification of a surgeon—and follow them through and after operation, learning his technique at the operating-table and soon finding himself competent to handle most of his patients alone. He now becomes what many allude to—often contemptuously—as the "occasional operator," meaning that he does general work but operates upon patients whom he feels he can do as well by as the men he was in the habit of calling in to help him. For him post-graduate study in surgery, when undertaken, will be built upon a broad medical experience.

ECONOMICAL ADVANTAGE OF PLAN

Economically, the new doctor who starts out to do surgery, even although he has learned a great deal of technique during the operative assistance he has rendered in his intern year, finds that he is called in mainly for children's and old peoples' maladies at first, and when he does get a chance to operate his knowledge and courage, manifested for operations at the end of his hospital service, fail him and he does best if he calls in an experienced surgeon to assist him. He is apt to encounter financial difficulties also if he does not take up general work, as his chances for adequate fees are small indeed. If he starts general practice soon after his graduation, he is more likely to immediately begin to do something, while if he continues with post-graduate study he adds more expense to the costly medical course he has just ended. Do not construe the above as being against either post-graduate study or specialization, as both are highly necessary for the advancement of medicine and surgery. The only question is: Should they be preceded by a practical medical general foundation or not?

YOUNG GRADUATE AS FAMILY PHYSICIAN

A period of years in general practice will tend to meet the growing shortage of that noble character and pioneer in our modern history, the family physician, whose passing is bemoaned by many prominent medical and lay leaders. Families in the city and country want the general practitioner, to whom they may go with all their ailments and, while it may be well that the old, overworked family physician is not as common as before, it will always be desirable to keep up the custom of having doctors—preferably young, active ones—who will be in a position to serve as general medical advisers, calling in specialists whenever needed. And who better than the recent graduate, with the progress of medicine just reviewed, can serve in this capacity with profit to his patients and himself?

THE CONSERVATIVE TREATMENT OF ECLAMPSIA

By MARGARET SCHULZE *

Prenatal care is a most important factor in the elimination of eclampsia. A well-controlled service will show far fewer cases, and these of milder type than an emergency service.

Pre-eclamptic toxemia should receive immediate and carefully controlled medical treatment in a hospital, and unless the condition subsides promptly, the pregnancy should be terminated, either by induction of labor or in carefully selected cases by Caesarean section.

In the treatment of eclampsia itself, radical operative measures, as Caesarean section and accouchement force, add very materially to the maternal risk, both in mild and severe cases. Mild cases do comparatively well under any type of treatment, yet even here the risk is doubled by radical intervention, while the chance for recovery of a severe case is very markedly decreased by the trauma of an operative intervention. Reliance should, therefore, be placed on morphin and eliminative measures, and no attempts at delivery should be made until the cervix is dilated. The value of venesection is not fully established, since Lichtenstein, Williams, and others report excellent results from its use, while the British Commission found a higher mortality in cases where it had been employed.

The interest of the child cannot be argued in favor of radical intervention, since its chances depend first, on its maturity; second, on the severity of the toxemia, and only very slightly on the method of delivery.

Cases of eclampsia which show no sign of the onset of labor during the course of conservative treatment should have labor induced, since this does not add to the maternal risk, while death of the fetus or continuance of the maternal toxemia is the rule in this type of patient.

DISCUSSION *by P. O. Sundin, Los Angeles; H. J. Ring, Ferndale; Harry S. Fist, Los Angeles; E. N. Ewer, Oakland.*

SINCE eclampsia is one of the most serious complications with which the obstetrician has to deal, its treatment becomes a matter of the greatest practical interest. In spite of most extensive investigation, its etiology remains unknown and its treatment, therefore, at present empirical.

With the development of the toxemia theory of the disease, it seemed entirely logical that the best way to treat a toxemia occurring only in the pregnant state was the most rapid possible termination of the pregnancy. Accordingly, radical operative delivery by Caesarean section, first recommended by Dührssen in 1891, or by vaginal hysterotomy or accouchement force, came to be so generally accepted that, in spite of extremely bad results, any recommendation of greater conservatism met with very little favor. Stroganoff's first report at the Paris Congress of 1900 of ninety-nine cases with a mortality of 5 per cent, in spite of the excellence of the results, made comparatively little impression, and it was only after he had personally demonstrated his method in a number of clinics that it began to be accepted there. Conservative treatment, with the emphasis on eliminative measures, has been practiced at the Rotunda Hospital in Dublin since 1903 with a mortality varying from 8 to 12 per cent, yet was almost unknown in other parts

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